REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

A REVIEW OF THE STATE DEPARTMENT OF HEALTH SERVICES' MONITORING OF NURSING HOMES

P-667 **JULY 1987**

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Thomas W. Hayes
Auditor General

July 8, 1987

P-667

Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the State Department of Health Services' monitoring of nursing homes.

Respectfully submitted,

THOMAS W. HAYES
Auditor General

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SUMMARY

RESULTS IN BRIEF

The State Department of Health Services (department) is not fulfilling two of its responsibilities that help to ensure quality care in nursing homes; as a result, nursing home patients are sometimes exposed for a prolonged time to conditions that are unsafe and unhealthy. During our audit, we noted the following conditions:

- The department did not investigate 26 percent of the complaints in our sample by the statutory deadline; and

- The department conducted only 35 percent of the follow-up visits that it was required to conduct after licensing inspections.

In March 1987, the department completed a workload study for the Legislature that proposes 142 additional staff for the department's Field Operations Branch, which is responsible for investigating complaints and conducting inspections of nursing homes.

BACKGROUND

The department is responsible for ensuring that nursing homes provide quality health care to California's chronically ill or convalescent patients. The department periodically inspects the nursing homes and notifies them of any deficiencies that it identifies. The nursing homes must then submit a plan stating how and when they will correct these problems. The department may also inspect a nursing home to investigate a complaint, which the department attempts to do within specified deadlines.

PRINCIPAL FINDINGS

The Department Does Not Always Investigate Complaints By Specified Deadlines

At the four district offices we visited, the department issued 31 of 80 citations in our sample as a result of investigating complaints. Of these 31 complaints, the department did not investigate 8 (26 percent) within the ten working days required by statute and, also, did not investigate 7 within the deadline required by department policy. When the department does not investigate complaints promptly, conditions that threaten the health and safety of patients remain uncorrected for a prolonged time.

The Department Does Not Always Conduct Follow-up Visits After Licensing Inspections

The department conducted only 52 (35 percent) of 149 required follow-up visits for the 80 nursing homes in our sample. The department followed up on deficiencies identified during state licensing inspections only while following up on deficiencies identified during federal certification inspections. Because the department does not conduct follow-up visits after all inspections, many nursing homes do not make an effort to correct deficiencies. Of the 52 follow-up visits the department made to nursing homes in our sample, the department found that, in 26 instances, nursing homes still had not corrected many deficiencies that the department had previously identified during licensing inspections. As a result, conditions that affect the health and safety of patients remain uncorrected.

RECOMMENDATION

To ensure that all complaints are investigated promptly and follow-up visits are conducted after licensing inspections, the State Department of Health Services should continue its efforts to obtain additional staff.

AGENCY COMMENTS

The department fully agrees that it should promptly investigate complaints and conduct follow-up visits after all licensing inspections as statutes require. The department reports that it has already started the process of hiring additional staff. The department also fully agrees with our recommendation to monitor nursing homes to determine whether they have resident councils, document this review, and issue deficiencies to nursing homes that are not in compliance.

INTRODUCTION

The State Department of Health Services (department), through Licensing and Certification, is responsible for ensuring that long-term health care facilities (most of which are commonly known as nursing homes) provide quality health care to California's chronically ill or convalescent patients. As of October 1986, the department was responsible for monitoring approximately 1,200 nursing homes capable of providing care to about 112,800 patients.

The department enforces the health care standards of both the State and the federal government. For fiscal year 1986-87, the budget for Licensing and Certification totaled approximately $22.3 million. The State contributed approximately $10.4 million of that amount, and the federal government is expected to contribute almost $11.9 million. The health care standards of the State are specified in the California Health and Safety Code, the Welfare and Institutions Code, and Title 22 of the California Administrative Code. The Health and Safety Code requires all nursing homes to obtain a license from the department to provide care to patients. To be licensed, a nursing home must meet the health care standards of the State. The health care standards of the federal government are specified in Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. Through the Health Care Financing Administration of the United States Department of Health and Human Services, the federal government contracts with the State to certify nursing homes that meet federal standards and, therefore, are authorized to participate in the Medicare and Medicaid programs.

Inspections

The department enforces the state and federal standards by conducting inspections of nursing homes to ensure the health and safety of patients. Inspections are conducted from 15 district offices, 11 administered by the State and 4 administered by Los Angeles County through a contract with the State. Inspections are unannounced and are usually conducted by teams of three people, one or two of whom are registered nurses.

The department can conduct state licensing and federal certification inspections either separately or at the same time. For state licensing, according to the Health and Safety Code, the department must inspect nursing homes annually; however, if the nursing homes have not been cited within the previous 12 months for a violation of health care standards, the Health and Safety Code requires licensing inspections at least once every two years. In addition to these periodic inspections, the department may also inspect a nursing home to investigate a complaint. For every inspection it conducts, the department notifies the nursing home of any deficiencies, and the nursing home is then required by department policy to submit a plan stating how and when it will correct them.

Finally, to be eligible to receive federal reimbursement through either the Medicare or Medicaid programs, a nursing home enters into an agreement with the Health Care Financing Administration of the

United States Department of Health and Human Services to comply with the health care standards of the federal government. If, during a federal certification inspection, which is conducted annually, the department finds that the nursing home is not complying, the nursing home may be decertified and, therefore, lose federal reimbursement.

Citations

According to the Health and Safety Code, during an inspection or investigation, the director of the department must issue a citation if he or she determines that a nursing home has violated any health care standard that has more than a minimal relationship to the health and safety of patients. The Health and Safety Code classifies violations as either "Class AA," "Class A," or "Class B." "Class AA" is a violation that causes the death of a patient; "Class A" is a violation that causes either imminent danger or substantial probability of death or serious harm to a patient; and "Class B" is a violation that has a direct or immediate relationship to the health and safety of patients although death or serious harm is not probable. The Health and Safety Code also allows the department to issue citations to nursing homes for willfully falsifying a patient's records or omitting from a patient's records information related to the patient's health and safety. Depending on the class of the citation, the department assesses the nursing home a penalty ranging from $100 to $25,000. For each violation identified, the evaluator requires the nursing home to submit a plan stating how and when the nursing home will correct the

violation. The department's policy requires that the evaluator who issues the citation conduct a follow-up visit to ensure that the violation is corrected.

Resident Councils

The Health and Safety Code requires most nursing homes to maintain resident councils and requires the department to notify nursing homes that fail to have these councils that they are not in compliance. These councils include residents and may include family members, nursing home staff, and other groups interested in the residents. Through the councils, which must meet at regular intervals and maintain minutes, residents may make recommendations concerning their own care and treatment.

SCOPE AND METHODOLOGY

The purpose of this audit was to evaluate the department's compliance with state laws related to nursing homes. We focused on sections of the California Health and Safety Code and Title 22 of the California Administrative Code that specifically relate to conducting licensing inspections, issuing citations, responding to complaints, and establishing resident councils. In addition, we reviewed the department's Licensing Procedures Manual to identify policies and procedures that staff are to follow in conducting inspections, issuing citations, and responding to complaints.

To evaluate the department's compliance, we visited the district offices of Licensing and Certification in Sacramento, San Francisco, San Diego, and West Los Angeles. From these four district offices, we selected a sample of 80 citations that the department issued to 80 different nursing homes between July 1, 1985, and December 31, 1986. These 80 citations represent 11 percent of all citations the four district offices issued to nursing homes during the period covered by our review. We examined the files for the 80 nursing homes that received these citations to determine whether licensing inspections conducted during 1985 and 1986 were conducted frequently enough and in accordance with the relevant statutes. We did not evaluate the thoroughness of the inspections. We also reviewed these files to determine whether the department issues citations appropriately and, for those citations resulting from complaints, to determine whether the department responds to complaints by specified deadlines. In addition, we interviewed department officials, district administrators, supervisors, and evaluators to obtain information on resident councils and to identify department policies and procedures used in conducting inspections, issuing citations, and responding to complaints.

Finally, in our review of the following areas, we found few weaknesses. We reviewed the department's compliance with policies about the frequency of inspections and the issuing of citations, and we determined the appropriateness of the department's civil penalties. In addition, we evaluated whether the department responds promptly to

those nursing homes that wish to appeal a citation. Further, we tested the procedures that the department uses to ensure that nursing homes pay their employees the appropriate wage and benefit increases that the Legislature has authorized.

AUDIT RESULTS

THE STATE DEPARTMENT OF HEALTH SERVICES DOES NOT ALWAYS PROMPTLY INVESTIGATE COMPLAINTS AND DOES NOT ALWAYS CONDUCT FOLLOW-UP VISITS AFTER LICENSING INSPECTIONS

The State Department of Health Services (department) does not always investigate complaints about nursing homes by specified deadlines and does not always conduct follow-up visits after licensing inspections. As a result, patients are sometimes exposed for a prolonged time to conditions that are unsafe or unhealthy. The chief of the Program Support Branch of Licensing and Certification and district administrators state that a staff shortage prevents the department from investigating complaints promptly and conducting follow-up visits after inspections. However, the department has submitted to the Legislature a workload study that proposes 142 additional staff for the Field Operations Branch, which is responsible for investigating complaints and conducting inspections of nursing homes. However, we did not independently analyze the workload study.

The Department Does Not Always Investigate Complaints by Specified Deadlines

The Health and Safety Code requires the department to conduct an inspection or investigation within ten working days of receiving a complaint regarding a nursing home unless the department determines that a complaint has no validity. However, the department's policy is

to investigate all complaints it receives and to assign priorities to them. Complaints assigned a "Priority 1," which allege an imminent threat to the life and safety of a patient, must be investigated within 24 hours. Complaints assigned a "Priority 2," which allege a direct or immediate relationship to the health, safety or security of a patient, must be investigated within ten working days; and complaints assigned a "Priority 3," which are all other complaints that do not allege an imminent threat to life or a direct or immediate relationship to the health and safety of a patient, must be investigated within 90 working days. According to the chief of the Program Support Branch of Licensing and Certification, complaints relating to nursing homes should not be assigned a priority 3.

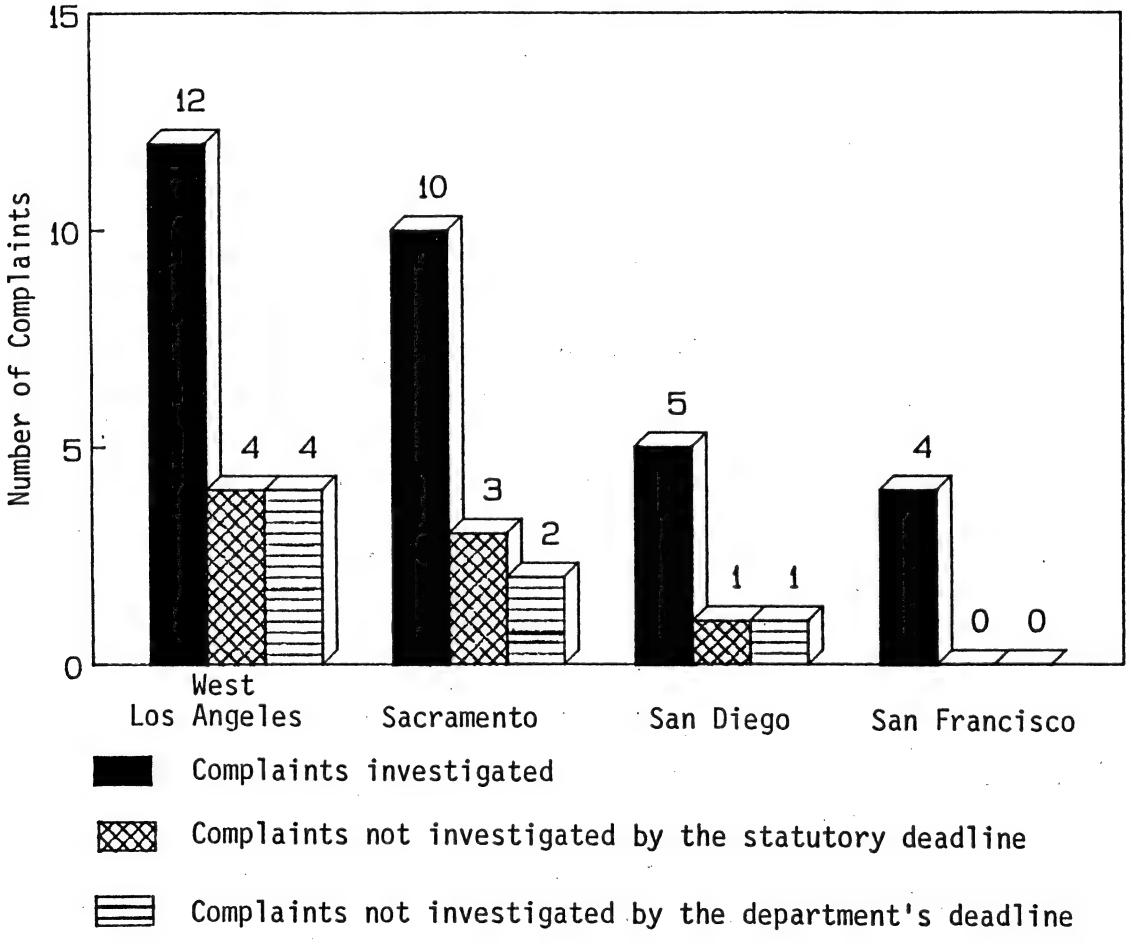
At the four district offices we visited, the department issued 31 of the 80 citations in our sample as a result of investigating complaints. Although the four district offices followed consistent procedures in processing complaints, three of the offices, as Chart 1 illustrates, did not investigate 8 (26 percent) of the 31 complaints by the ten-day deadline specified by statute. Instead, the department took an average of 21 working days before it investigated these eight complaints with the length of the delays ranging from 11 to 35 working days from the dates the department received the complaints.

In addition, the department does not always investigate complaints by the deadline required by department policy. Although the department investigated by its 24-hour deadline the two complaints in

our sample that it assigned a priority 1, the department did not investigate by its ten-day deadline, 7 (26 percent) of 27 complaints that it assigned a priority 2.* Instead, the department took an average of 22 working days before investigating these 7 complaints with the length of the delays ranging from 12 to 35 working days.

CHART 1

STATE DEPARTMENT OF HEALTH SERVICES
LATE INVESTIGATIONS
FOUR DISTRICT OFFICES
SAMPLE OF 31 COMPLAINTS
JULY 1, 1985 THROUGH DECEMBER 31, 1986



*The department inappropriately assigned a priority 3 to two of the 31 complaints in our sample; however, the department took only 6 days to investigate one of these complaints and 11 days to investigate the other.

The prompt investigation of complaints is important to protect patients in nursing homes from substandard levels of care. For example, in one instance, the department received a complaint regarding a nursing home's treatment of patients with decubitus ulcers, commonly known as bedsores, which develop when a patient continuously lies or sits in the same position without moving. In their advanced stage, these sores will progress into the muscle and bone. The department assigned this complaint a priority 2 and investigated it within five working days. During the complaint investigation, the department found that the nursing home failed to plan, provide, and document skin care for at least 84 patients who, according to the nursing home, were prone to the development of bedsores. In this instance, the department's prompt investigation was important to those patients who were at risk of forming bedsores or having existing bedsores enlarge.

When the department does not investigate complaints promptly, it can prolong the existence of unsafe conditions and, therefore, jeopardize the health and safety of patients. For example, one district office did not promptly investigate a complaint that was assigned a priority 2 and that alleged that a patient received third-degree burns on his leg. During the complaint investigation, the department found that the nursing home had failed to install the proper screens for a wall heater in a patient's room and the nursing home's lounge. As a result, a patient burned his thigh when his wheelchair bumped against a wall heater. The evaluator who conducted the investigation concluded that the nursing home's failure to maintain

proper screens on the heaters presented a direct or immediate threat to the health and safety of patients. However, this unsafe condition continued to exist for 32 days before the department investigated the complaint and identified the problem.

The Department Does Not Always Conduct Follow-Up Visits After Licensing Inspections

According to the Licensing Procedure Manual, evaluators must conduct follow-up visits after licensing inspections that identify deficiencies. In addition, the California Health and Safety Code allows the department's director to take action to revoke or suspend a nursing home's license if a follow-up visit shows that a nursing home has not corrected these deficiencies. The federal government also requires the department to follow up on certification inspections that identify noncompliance with certain health standards, and the federal government can discontinue reimbursement to a nursing home that does not comply with them.

For the nursing homes in our sample, the department was required to conduct follow-up visits after 149 licensing inspections it conducted in 1985 and 1986. However, the department conducted only 52 (35 percent) of these required follow-up visits and only when evaluators were also required to follow up after a certification inspection for the federal government.

According to the deputy director of Licensing and Certification, because of a staff shortage, the department currently conducts follow-up visits after certification inspections that identify noncompliance with certain health standards but not after all licensing inspections. The reason for this practice is that the State has a contract with the federal government to certify those nursing homes that have no deficiencies that jeopardize the health and safety of patients. Nursing homes that are not certified are not eligible to be reimbursed for care provided to patients receiving Medicare and Medicaid, which can result in these patients being relocated to other nursing homes.

District administrators and staff at the four district offices agreed that follow-up visits are important to ensure that nursing homes correct deficiencies. They also stated that nursing homes are aware that the department does not conduct follow-up visits as required. The chief of the Program Support Branch of Licensing and Certification stated that because nursing home staff know that the department does not conduct follow-up visits after all inspections, many nursing homes do not make an effort to correct the deficiencies. As a result, conditions that affect the health and safety of patients remain uncorrected.

Of the 52 follow-up visits that the department made to nursing homes in our sample, the department found that in 26 (50 percent) instances nursing homes still had not corrected many deficiencies that

the department had previously identified. For example, during a combined certification inspection and licensing inspection in October 1985, the department identified numerous deficiencies, according to the health care standards of both the federal government and the State. For example, the department found that the nursing home's kitchen had roaches and flies. In addition, plastic garbage bags inside garbage bins were open and could attract insects and rodents. The evaluator and the nursing home agreed on dates by which the nursing home should correct these deficiencies, and when the evaluator conducted a follow-up visit in January 1986 to satisfy federal requirements, she also followed up on deficiencies identified during the licensing inspection.

During the follow-up visit, the evaluator found that the nursing home had not corrected the deficiencies. As a result, the evaluator issued two "Class B" citations and fined the nursing home $1,000 for each violation. In issuing the "Class B" citations, the evaluator concluded that the nursing home's failure to provide a clean, sanitary environment that was free of vermin had a direct and immediate relationship to the health and safety of all patients. The nursing home was required to provide a new date to correct the violations, and when the evaluator conducted the follow-up visit on this date, the evaluator found that the nursing home had made the required corrections.

The department needs to conduct more follow-up visits than it is presently conducting to ensure that conditions that threaten the health and safety of patients are corrected. For example, during a licensing inspection in November 1986 for one of the nursing homes in our sample, the evaluator noted several deficiencies concerning nursing services. The evaluator noted that several patients had received inadequate medical attention: two patients had experienced significant weight loss that the nursing home had not reported to the patients' physicians, two patients were administered medication inappropriately, and, finally, two patients were lying in filth without call lights in reach. As of June 12, 1987, the department had not conducted a follow-up visit.

Proposal To Add Staff

According to the chief of the Program Support Branch of Licensing and Certification and three district administrators and a district supervisor at the four district offices we visited, a staff shortage prevents the department from investigating complaints promptly and conducting follow-up visits after licensing inspections. The department has completed a workload study and has requested additional staff; however, we did not independently analyze either the workload study or the staffing proposal.

In the Analysis of the Budget Bill for fiscal year 1986-87, the Legislative Analyst reported that the department was not always

promptly conducting licensing inspections for primary care, community, and Short-Doyle clinics, nor was the department always promptly conducting certification inspections. The Legislative Analyst also noted that the department did not investigate within ten working days 34 percent of the complaints it received in November 1985. In addition, the Legislative Analyst reported that the department's budget made no provision for the resources needed to eliminate the backlog of work. As a result, the Supplemental Report of the 1986 Budget Act requested the department, in consultation with the Legislative Analyst and the Department of Finance, to design and conduct a study of the licensing and certification workload and to develop staffing standards for consideration during the 1987-88 budget process.

The department completed the workload study in March 1987. A steering committee, composed of representatives from the Department of Finance, the Legislative Analyst's Office, and the Department of General Service's Management and Consulting Services, provided consultation to the department and reviewed the report. The study concludes that Licensing and Certification is significantly understaffed in seven areas and proposes additional staff for these areas to be added over three years. The study proposes 142 additional staff for the Field Operations Branch, which is responsible for conducting inspections and for investigating complaints. These 142 staff represent an increase of 63 percent over the 227 field staff the department currently has. The study also proposes funds for an additional 40 field and support staff for the four district offices in

Los Angeles County. These 40 staff represent an increase of 34 percent over the 119 field staff the Los Angeles region currently has. In May 1987, as the first phase of the two-to-three-year plan to bring Licensing and Certification up to new staffing levels consistent with the workload study, the Department of Finance and the Legislative Analyst recommended to the Legislature that, for fiscal year 1987-88, the department receive 50.4 positions for its field offices and an additional 6.3 positions for its headquarters.

The Department Does Not Document Whether Nursing Homes Have Resident Councils

The Health and Safety Code requires nursing homes to establish and maintain a resident council, which must meet at regular intervals and maintain minutes. These councils include residents and may include family members, nursing home staff, and other groups interested in the residents. Through the councils, residents may make recommendations concerning their care and treatment. As of January 1, 1987, the Health and Safety Code was amended to also require the department to notify nursing homes that have not established resident councils that they are not in compliance. These nursing homes are required by department policy to develop a plan stating how and when the problem will be corrected.

None of the 12 evaluators we interviewed document whether they review resident councils. However, 10 of the 12 evaluators stated

that, although they keep no documentation, they do check, or sometimes check, during licensing inspections to ensure that nursing homes have resident councils. Of the two remaining evaluators we interviewed, one stated that she is aware that resident councils are required but does not check to ensure that nursing homes have these resident councils; the other evaluator we interviewed stated that she did not know that resident councils are required and, therefore, does not check to ensure that nursing homes have councils.

Of the ten evaluators that do check to ensure that nursing homes have resident councils, eight evaluators review the minutes of resident council meetings while two of the evaluators review the minutes occasionally. Six of the ten evaluators interview patients regarding these councils, and three of the ten observed a resident council meeting during a licensing inspection. However, because evaluators do not document whether nursing homes have established resident councils, we are unsure that the department is enforcing the law that requires all nursing homes to have these councils.

Several evaluators told us that they do not document whether nursing homes have resident councils because the department has not emphasized this issue or provided guidelines for reviewing resident councils. The chief of the Program Support Branch of Licensing and Certification stated that the department had not directed evaluators to monitor nursing homes to ensure that they have resident councils because it is a new requirement to notify nursing homes that are not in

compliance. In response to our audit work, the department has drafted a policy to all evaluators that includes instructions to monitor resident councils and to notify any nursing home that fails to maintain a council that it is not in compliance with the law. However, this policy does not require evaluators to document their reviews.

CONCLUSION

The State Department of Health Services does not always investigate complaints about nursing homes by specified deadlines and does not always conduct follow-up visits after licensing inspections. As a result, patients are sometimes exposed for a prolonged time to conditions that are unsafe or unhealthy. The chief of the Program Support Branch of Licensing and Certification and district administrators state that a staff shortage prevents the department from investigating complaints promptly and conducting follow-up visits after inspections. However, the department has taken steps to resolve the staffing shortage.

In addition, the department does not document whether nursing homes have established resident councils. Consequently, we are unsure whether the department is enforcing the law that requires all nursing homes to have these councils.

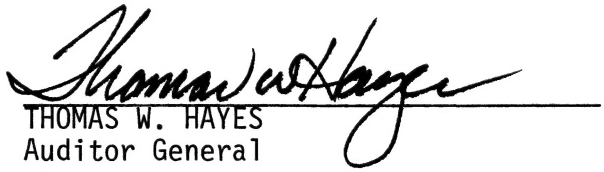
RECOMMENDATIONS

To ensure that it investigates complaints promptly and conducts follow-up visits after licensing inspections, the State Department of Health Services should continue its efforts to obtain additional staff.

To ensure that nursing homes establish and maintain resident councils, the department should monitor nursing homes to determine whether they have resident councils, document this review, and require nursing homes that are not in compliance to establish resident councils.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: July 6, 1987

Staff: Steven L. Schutte, Audit Manager
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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
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June 30, 1987

Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

Dear Mr. Hayes:

Mr. Allenby has asked me to respond to your draft report "A Review of the State Department of Health Services Monitoring of Nursing Homes."

The Department fully agrees that complaint investigations and follow-up visits should be conducted on a timely basis within statutory requirements. As your report indicates, the Department has just completed, with the assistance of the Legislative Analyst's Office and the Department of Finance, a workload study which identifies, among other things, the additional staff needed to accomplish timely investigations and follow-ups. The workload study resulted in an April 1987 Finance Letter which proposed a significant staffing augmentation over a three year period. The position increases for 1987-88, associated with the Finance Letter, have been included in the 1987-88 Budget Bill. Preparation for the hiring of the additional staff has already started.

The Department also fully agrees with your other recommendation that we should monitor nursing homes to determine whether they have resident councils. As you indicate in your report, the Department has been working on appropriate monitoring instructions for our field evaluators. These instructions will be released on or about July 1, 1987 and will be effective August 1, 1987. They will instruct the field evaluators to ensure:

a. That the council is meeting at regularly scheduled intervals.

b. That written minutes are maintained and that the minutes are available to the Department.

c. That minutes of the council meeting are provided to the licensee.

d. That the licensee has reviewed the minutes and that any recommendations from the council have been acted upon by the licensee.

e. That facility policies do not restrict the right of patients to meet independently with persons outside of the facility or facility staff as determined by the patient.

f. That family members of patients are invited to the meeting of the resident council.

Failure of any facility to implement the requirements for resident councils will be documented and will result in the facility being issued a deficiency statement. The licensee will be expected to take immediate corrective action.

Please contact me at 445-1248 or Virgil J. Toney, Jr., Deputy Director, Licensing and Certification at 445-3054, if you have any questions concerning this response.

Sincerely,

Kenneth W. Kizer, M.D., M.P.H.
Director

cc: Clifford L. Allenby, Secretary
Health and Wefare Agency

HD4683 (201)

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps